Haemophilus influenzae B (HIB)

Agency:

Investigator: Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name:
First and middle name:
Maiden name: Suffix:
Address line:
Zip: City:
State: County:
Phone: ( )- - Type:
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name:

Date of Birth: / / Estimated? ☐ Age:
Gender: ☐ Female ☐ Male ☐ Other
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name:
Parent/Guardian phone: ( )- - Type:

EVENT

Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Date of Death / / ☐ Unknown
Event exception: ☐ Case could not be found ☐ Case could not be interviewed ☐ Case refused interview ☐ Other – see notes
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name:
Exposure setting:
Epi-linked: ☐ Yes ☐ No ☐ Unk To whom:
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: Country:

Healthcare provider information

Last name:
First name:
Provider title: ☐ ARNP ☐ MD ☐ PA ☐ DO ☐ NP
Facility name:
Address line 1:
Address line 2:
Zip code: City:
State: County:
Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory:
Date received: / /
Result type: ☐ Preliminary ☐ Final
Accession #:
Specimen source:
Test type: ☐ Gram stain ☐ PCR ☐ Latex agglutination ☐ Culture ☐ Immuno-histochemistry
Collection date: / /
Result date: / /
Result: ☐ Positive ☐ Negative ☐ No growth
Serogroup: ☐ A ☐ B ☐ C ☐ W-135 ☐ Y
Organism: ***Neisseria meningitidis***

Laboratory:
Date received: / /
Result type: ☐ Preliminary ☐ Final
Accession #:
Specimen source:
Test type: ☐ Gram stain ☐ PCR ☐ Latex agglutination ☐ Culture ☐ Immuno-histochemistry
Collection date: / /
Result date: / /
Result: ☐ Positive ☐ Negative ☐ No growth
Serogroup: ☐ A ☐ B ☐ C ☐ W-135 ☐ Y
Organism: ***Neisseria meningitidis***

Laboratory: _____ Specimen source: _____ Result: ☐ Positive ☐ Negative ☐ No growth

Date received: / / Test type: ☐ Gram stain ☐ PCR ☐ Latex agglutination ☐ Gram stain ☐ Culture ☐ Immuno-histochemistry

Result type: ☐ Preliminary ☐ Final Collection date: / / Serogroup: ☐ A ☐ B ☐ C ☐ W-135 ☐ Y

Accession #: Result date: / / Organism: ***Neisseria meningitidis***

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Admission date: / / Discharge date: / /

Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____

Days hospitalized: _____ Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type: _____

CLINICAL INFO & DIAGNOSIS

Purpura fulminans present: ☐ Yes ☐ No ☐ Unk

Infection type: ☐ Primary bacteremia ☐ Meningitis ☐ Pericarditis ☐ Epiglottitis ☐ Peritonitis ☐ Pneumonia ☐ Arthritis ☐ Septecemia ☐ Other _____

Other infection type (specify):

Spinal tap performed ☐ Yes ☐ No ☐ Unk Date / /

Normal ☐ Yes ☐ No ☐ Unk

Spinal Fluid Results

Protien _ __unit Glucose _ __unit White Blood Count _ __unit

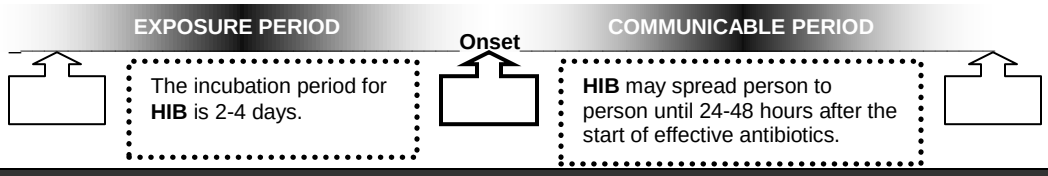
TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic:	Antibiotic:	Antibiotic:
Date started: / /	Date started: / /	Date started: / /
Dose:	Dose:	Dose:
Unit: ☐ mg ☐ ml ☐ IU # of days:	Unit: ☐ mg ☐ ml ☐ IU # of days:	Unit: ☐ mg ☐ ml ☐ IU # of days:
# of times a day: Route:	# of times a day: Route:	# of times a day: Route:

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Vaccinated for *Haemophilus influenzae* type B: ☐ Yes ☐ No ☐ Unknown

Date vaccinated: / /	Date vaccinated: / /	Date vaccinated: / /
Lot #:	Lot #:	Lot #:
Vaccine type:	Vaccine type:	Vaccine type:
Manufacturer:	Manufacturer:	Manufacturer:

Number of vaccinations: ____

CONTACTS

Number of people living in case's household: _____ **Number of people living in case's home age 3 or less :** _____

Close contacts of the case: ☐ Yes ☐ No ☐ Unknown

Close contacts of the case

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

PROPHYLAXIS

Vaccinated for HIB: ☐ Yes ☐ No ☐ Unknown

Date vaccinated: / /

Lot #:

Vaccine type:

Manufacturer:

Antibiotics prescribed: ☐ Yes ☐ No ☐ Unknown

Antibiotic:

Date started: / /

Dose:

Unit: ☐ mg ☐ ml ☐ IU

# of times a day: Route:

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

PROPHYLAXIS

Vaccinated for HIB: ☐ Yes ☐ No ☐ Unknown **Antibiotics prescribed:** ☐ Yes ☐ No ☐ Unknown

Date vaccinated: / / Antibiotic:

Lot #: Date started: / /

Vaccine type: Dose:

Manufacturer: Unit: ☐ mg ☐ ml ☐ IU

# of times a day: Route:

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

PROPHYLAXIS

Vaccinated for HIB: ☐ Yes ☐ No ☐ Unknown **Antibiotics prescribed:** ☐ Yes ☐ No ☐ Unknown

Date vaccinated: / / Antibiotic:

Lot #: Date started: / /

Vaccine type: Dose:

Manufacturer: Unit: ☐ mg ☐ ml ☐ IU

# of times a day: Route:

NOTES: